TennCare Quarterly Report

Submitted to the TennCare Oversight Committee and the Fiscal Review Committee

January 15, 2003

Status of TennCare Reforms and Improvements

Implementation of new waiver
Work continued during the October-December quarter on notifying enrollees regarding having their eligibility redetermined, with the last mass mailing going out September 30, 2002. Several smaller mailings occurred after that date.

With each mailing, individuals were given up to 90 days to go through the redetermination process at DHS and prove that they met the criteria for either Medicaid or one of the demonstration categories in the new waiver. Those who had not yet made an appointment at DHS within 30 days after the mailing was sent received follow-up letters reminding them that only 60 days remained.

A number of advocacy efforts were continued to assist people in understanding the importance of following through with this process. Information line efforts at the TennCare Consumer Advocacy Line and the TennCare Partners Advocacy Line were expanded. Materials have been printed in Spanish, and access to six other languages is being provided—Bosnian, Arabic, Somali, Vietnamese, and two dialects of Kurdish (Sorani and Badinani). TennCare sends the Advocacy Lines the names of persons who have not responded to requests to make appointments at DHS, and these Lines attempt to locate these people and offer assistance where necessary.

Around the first of December, a letter went out to all TennCare enrollees informing them of the benefit and copay changes that were due to take effect on January 1, 2003.

On December 18, 2002, a decision was handed down by the Federal Court in Nashville that prevented the state from implementing the revised benefit plan and also called for the reinstatement of every person who had been disenrolled from TennCare through the redetermination process since July 1, 2002. The state appealed this decision to the Sixth Circuit Court in Cincinnati. On December 29, 2002, the state reinstated those who had been disenrolled since July 1, 2002, as a result of the redetermination process. These reinstatements were subsequently reversed on January 3, 2003, after an emergency stay of the Order was issued by the Sixth Circuit Court. Another letter went out to all enrollees informing them that the planned benefit and copay changes would not take effect on January 1, 2003. A stay pending the outcome of the state's appeal was issued by the Sixth Circuit on January 13, 2003.

TennCare Advisory Board
A 14-member TennCare Advisory Board was appointed during this quarter. The Board, whose members have been asked to serve one- to three-year renewable terms, met for the first time during the quarter.

Dental carve-out
On October 1, 2002, implementation of the TennCare Dental Carve-Out began. Dental services are now being provided statewide through one Dental Benefits Manager contracted with the state on an administrative services basis. The DBM is Doral Dental of Tennessee.

On September 23, 2002, one week before the dental carve-out, the TennCare dental network consisted of a total of 386 dentists. By January 10, 2003, there were 693 dentists who had returned signed provider agreements and 617 dentists who had completed the credentialing process. This represents a 60 % increase in the dental provider network in the first three months of the program.

Presentations, journal articles, newsletters, and press releases by the American Dental Association, the Tennessee Dental Association, the Pan Tennessee Dental Association, and the Bureau of TennCare have been effective in promoting the carve-out and in encouraging dentists in Tennessee to participate in the program.

The TennCare Dental Advisory Committee, formerly known as the Children's Oral Health Planning Group, held its first official meeting on October 4, 2002, and has met on a monthly schedule thereafter. The Advisory Committee consists of 20 members who have been asked to review and make recommendations to Doral and TennCare concerning the dental program. This group has offered assistance in the development of policies and ensures that information is communicated to dentists across the state through their newsletters. At the group's request, the Directors of the TennCare Program Integrity Unit and the TBI Medicaid Fraud Control Unit have met with the committee to explain how best to monitor utilization and service delivery to prevent fraud or abuse in the dental program.

Besides working with Doral Dental, organized dentistry and the private dental sector in the financing and delivery of dental care, the TennCare Bureau is also working closely with the Department of Health's Oral Health Services section to provide statewide oral disease prevention. It is anticipated that over time these partnerships will result in measurable improvements in children's oral health in Tennessee.

Pharmacy update
1. **Medicare-covered drugs.** The TennCare pharmacy carve-out provides the complete pharmacy benefit for over 230,000 TennCare members eligible for both TennCare and Medicare (dually eligible members). Medicare covers a few outpatient drugs and TennCare has signed a management letter with a current contractor (PCG) to collect from Medicare any payments by TennCare for these drugs. On October 1, 2002, TennCare implemented a prospective process that switches to on-line, real time cost avoidance at the pharmacy level for Medicare-covered drugs.

2. **Pharmacy lock-in.** TennCare has reviewed and approved pharmacy lock-in procedures for certain members to receive all their prescriptions from a single pharmacy. Lock-in procedures not only reduce costs for needless or duplicative prescriptions, but also improve the quality oversight of the member's care.

3. **TennCare's Centers of Excellence project.** TennCare has implemented the TennCare Centers of Excellence project with Applied Health Outcomes (AHO). Three disease-specific Centers of Excellence (diabetes, cardiovascular, and asthma) have been launched. TennCare has received over $1,000,000 from pharmaceutical manufacturers to fund the project, which includes disease management interventions, quality improvement, cost containment strategies, and outcomes research. A major goal of the project is to provide physicians with evidence-based data that show the best treatment algorithm to follow for specific disease states. This approach provides physicians with the most current clinical thinking in order to effect voluntary changes in prescribing practices. Appropriate prescribing patterns that give the best outcomes ultimately save total health care costs by reducing expenditures for emergency room visits, hospitalizations, physician visits, and other service-related costs.

4. **Long-term care pharmacy.** TennCare and Vanderbilt have begun a study of long-term pharmacy dispensing practices and reimbursement. Expected to be completed on April 1, 2003, this report may change the current seven-day dispensing requirements in nursing facilities to a less expensive 30-day process.

5. **Single drug formulary.** Since the implementation of the TennCare program on January 1, 1994, the TennCare managed care organizations (MCOs) have covered well-defined lists of prescription and non-prescription drugs known as drug formularies. The Centers for Medicare and Medicaid Services, or CMS (formerly HCFA) approved TennCare's 1115 waiver application in November of 1993 and that waiver allows the MCOs to restrict drug coverage to these drug formularies.

   TennCare is making plans to implement a single drug formulary on April 1, 2003. The development and implementation of a uniform, single, statewide drug formulary that all TennCare MCOs would be required to manage will not only simplify prescribing for physicians, but also assure that all TennCare members have access to quality pharmacy services, while preserving the members' due process and appeal rights. Once the TennCare Formulary Committee has delivered a final drug formulary and prior approval criteria to the TennCare Bureau, the implementation phase of the project will begin.

   Each MCO will be required to launch a prescriber education initiative as part of the implementation phase. Provider educational efforts may include direct mailings to network providers, collaboration with the Tennessee Medical Association (TMA), continuing education programs for physicians, in-service training at network hospitals, broadcast facsimile transmissions to prescribers and website postings. TennCare will require physician members of the TennCare Formulary Committee to assist the educational effort by communicating with their peers and encouraging formulary compliance.

6. **Proposal to modify *Grier*.** The *Grier* Consent Decree requires pharmacists to dispense a 14-day supply of non-formulary medications when the prescriber cannot be reached or is unwilling to change the prescription to a covered drug. Additionally, the pharmacist is required to provide the TennCare member an appeal form with such 14-day dispensings. The TennCare Solutions Unit (TSU), which processes all member appeals, is presently receiving some 8,000 pharmacy appeals each month. More than 90% of these pharmacy appeals result in coverage of non-formulary drugs. Recent studies performed by PriceWaterhouseCoopers and Applied Health Outcomes place the pharmacy cost of TennCare MCO compliance with the *Grier* Consent Decree at about $50 million per year.

   On November 8, 2002, the state filed a Motion to Modify the Grier Revised Consent Decree in two areas. One was the set of provisions in the Consent Decree regarding pharmacy appeals; the other was the matter of expedited appeals. The proposed pharmacy modifications suggest that if, after the implementation of a single, statewide drug formulary, a TennCare member or dually eligible member presents a non-formulary, "medical" prescription for a drug in a covered therapeutic category and the physician is unavailable or unwilling to change the prescription to a formulary alternative, the pharmacist will dispense a five (5) day emergency supply of the medication. The pharmacy benefits manager (PBM) or pharmacy claims processor for the respective MCO will produce and send to the MCO (the next day) and TennCare a report of all such five (5) day prescriptions so the MCO or TennCare may process a prior approval (PA) for that prescription. This PA process may include permission by the prescriber to change the prescription to a formulary alternative or approval of the drug originally prescribed. In the event that the PA process is not completed in five (5) days, and the member needs more of the medication, then the pharmacist will dispense the balance of the original prescription. No pharmacy appeal will be generated since the member was not denied any pharmacy services. If the prescriber wishes to keep that patient on the non-formulary medication, then all future, valid prescriptions will be covered by the MCO or TennCare for that member. The MCO or TennCare may still contact the prescriber and offer formulary alternatives to the prescriber. If at any time, the prescriber changes the prescription to a formulary alternative, then coverage of the original, non-formulary medication may be discontinued by the MCO or TennCare.

   The hearing date for this Motion has not yet been set.

Reverification Status

As of January 10, 2003, about 240,000 individuals had fully completed the redetermination process. Almost 80,000 of these were found to be eligible for Medicaid, while more than 135,000 were found to be eligible for Standard. Just over 25,000 were found ineligible for Standard.

Others are still in the redetermination process. Because of the December Court Order mentioned above, persons in the process as of the date of the Order have not been terminated.

Status of Filling Top Leadership Positions in the Bureau

Darin Gordon was named MCO Director during this quarter. Stephanie Anderson was appointed to the position of Eligibility Coordinator, and Vicki Guye was named Audit Director.

Number of Recipients on TennCare and Costs to the State

As of the end of the quarter, there were 1,311,942 enrollees on TennCare: 942,973 Medicaid eligibles and 368,969 Uninsureds and Uninsurables.

During the second quarter of FY 2003, TennCare spent $1,171,884,446 (net projected drug rebates) for managed care services. These expenditures included: payments to the managed care organizations, payments to the behavioral health organizations, payments to the dental benefits manager, and payments for pharmacy services for the dual eligibles and behavioral health pharmacy carve-outs.

Viability of MCOs in the TennCare Program

Claims payment analysis for medical services
The prompt pay requirements of T.C.A. § 56-32-226(b) mandate that each health maintenance organization and behavioral health organization ensure that 90% of claims for payment for services delivered to a TennCare enrollee are paid within 30 days of the receipt of such claims and 99.5% of all provider claims are processed within 60 days of receipt.

In October 2002, TDCI requested data files of all TennCare processed medical claims from TennCare MCOs and BHOs for the month of October 2002. TDCI also requested data files of pended TennCare claims as of October 31, 2002, and a paid claims triangle from October 1, 2001, through October 31, 2002.

TDCI's analyses of these data files indicated that Xantus Healthplan of Tennessee, Universal Care of Tennessee and Memphis Managed Care were not in compliance with the statute. Premier Behavioral Health, Better Health Plans, Preferred Health Partnership, Volunteer State Health Plan, OmniCare Health Plan, John Deere Health Plan, Victory Health Plans and Tennessee Behavioral Health were in compliance.

For the three MCOs out of compliance with prompt pay requirements in October, TDCI requested claims payment data for November to assess whether the MCOs were back in compliance. For November, TDCI requested data files of all TennCare processed claims, TennCare pended claims and paid claims triangles from Xantus Healthplans of Tennessee, Universal Care of Tennessee and Memphis Managed Care. Memphis Managed Care was in compliance with prompt pay requirements in November, but Universal Care of Tennessee and Xantus Healthplan of Tennessee were not in compliance.

Because Universal Care of Tennessee and Xantus Healthplan of Tennessee were not in compliance with the prompt pay statute in October or November and because these two MCOs are monitored monthly for compliance under TDCI administrative supervision and rehabilitation (respectively), the TennCare Division will request and analyze medical data files for December 2002 for these two MCOs.

The division will also analyze data files monthly for Memphis Managed Care (including December) as a component of the division's continuing oversight of MMCC's claims payment system upgrade project.

As part of TDCI's cycle of analyzing claims data for the first month in each quarter, the division will review claims data for all MCOs and BHOs for January 2003.

Development of claims payment analysis for pharmacy benefits

TDCI has initiated the development of a system for analysis of claims payments for Pharmacy Benefits. This project is underway and requires TDCI to adjust its analysis techniques to be congruent with TennCare Pharmacy Benefit service delivery under Grier. TDCI requested data files of all TennCare processed pharmacy benefits claims from TennCare MCOs and/or subcontracted pharmacy benefits managers (PBMs) for the month of October 2002. Included in the request were data files of pended TennCare pharmacy claims as of October 31, 2002, and a paid claims triangle from October 1, 2001, through October 31, 2002. The behavioral health organizations, Premier and Tennessee Behavioral Health, were not part of this study as TennCare Partners Program Pharmacy Benefits are delivered by the TennCare Bureau through its contract with Consultec. (The BHOs are not required to provide pharmacy benefits because these benefits are provided by the state.)

TDCI's analyses of data files indicated that John Deere Health Plan and Volunteer State Health Plan were in compliance with prompt pay requirements for pharmacy claims. Xantus Healthplan of Tennessee, OmniCare Health Plan, and Memphis Managed Care were not in compliance.

For the three MCOs not in compliance for October, TDCI requested pharmacy claims data for November 2002. Xantus Healthplan of Tennessee, OmniCare Health Plan, and Memphis Managed Care were deemed to be back in compliance with prompt pay requirements for pharmacy claims for November 2002.

Better Health Plans, Preferred Health Partnership, Universal Care of Tennessee and Victory Health Plans were requested to resubmit October pharmacy data because of incomplete files or incorrect file formats. TDCI has not completed its analyses of these files.

Universal Care of Tennessee routinely submits pharmacy claims data monthly as part of TDCI's administrative supervision oversight. TDCI has requested Universal to resubmit its November data file because of incorrect file formatting.

Memphis Managed Care will submit pharmacy benefits data files for each month (including December) as a component of TDCI's oversight of MMCC's claims payment system upgrade project.

As part of TDCI's cycle of analyzing claims data for the first month in each quarter, the division will review pharmacy claims data for the appropriate MCOs for January 2003.

Net worth requirement

The most current financial statement filings for HMOs were submitted in December for the quarter ending September 30, 2002. TDCI will determine excess or deficient net worth for TennCare HMOs at December 31, 2002, when the annual 2002 NAIC financial statements are submitted March 1, 2003.

Listed below is each MCO's net worth requirement compared to net worth reported at September 30, 2002, on the NAIC third quarterly statement. Universal Care of Tennessee, Memphis Managed Care, Xantus and Premier reported a net worth deficiency. While TBH reported an excess net worth, TDCI has received information in January 2003 that indicates the TBH may well have a net worth deficiency at December 31, 2002.

MCO/BHO	REPORTED NET WORTH	NET WORTH REQUIREMENT	Note	EXCESS/(DEFICIENT) NET WORTH
Better Health Plans	3,367,322	2,956,800	(1)	410,522
John Deere	78,436,889	12,377,685		66,059,204
Memphis Managed Care	6,288,568	7,201,830		-913,262
OmniCare	4,690,307	4,544,249		146,058
PHP	17,134,161	6,821,720		10,312,441
Premier Behavioral Health	1,880,888	6,918,195	(3)	-5,037,307
TBH	12,387,192	5,514,875	(4)	6,872,317
Universal	5,670,183	6,522,000	(1) (2)	-851,817
VHP	6,320,987	1,816,510		4,504,477
Volunteer	56,178,328	16,673,233		39,505,095
Xantus	-76,887,334	7,998,884		-84,886,218

(1)These MCOs did not begin operations until July 1, 2001. The net worth requirement has been increased above the statutory minimum based on projected premium revenue.

(2)Universal is under the Administrative Supervision of the Commissioner of Commerce and Insurance as a result of identified financial and claims processing operations problems. Further regulatory actions by TDCI are subject to the response of the Centers for Medicare and Medicaid Services and the TennCare Bureau to the request by Universal for additional funding. The collectibility of this receivable is pending resolution by the Centers for Medicare and Medicaid Services and the TennCare Bureau. If this receivable is deemed uncollectible, TDCI will adjust Universal's reported net worth from $5,670,183 to ($37,117,197).

(3)Premier is under Administrative Supervision of the Commissioner of Commerce and Insurance as a result of its net worth deficiency. Effective January 1, 2003, the state assumed 100% of the financial risk for covered benefits.

(4)TBH was placed under an Order of Administrative Supervision on January 9, 2003 because TBH transferred $7 million of capital to its parent, Magellan Health Services, Inc., on October 4, 2002, without notifying TDCI and properly disclosing this transfer on its financial statements filed with TDCI on December 2, 2002. By transferring the $7 million in capital, TDCI estimates that TBH may have a net worth deficiency of approximately $200,000.

Universal Care of Tennessee
During the fourth quarter, TDCI continued to work closely with Universal to identify and correct claims processing errors. The Administrative Supervisor and TDCI examiners are closely monitoring Universal's cash balances, including review and approval of disbursements prior to the release of checks for claims payments. TDCI and Universal have developed procedures to facilitate issuing claims payment checks weekly.

Providers in Universal's network are most concerned about payments for claims with dates of service prior to 4/12/2002. As noted above, the TennCare Bureau and the Centers for Medicare and Medicaid Services are currently working together to achieve a resolution of the funding issues surrounding these claims.

TDCI contracted consultants were on site during the fourth quarter to follow up on their previous site visits to assess Universal's claims processing operations.

Memphis Managed Care
On June 12, 2002, TDCI received MMCC's revised plan of corrective action relative to its net worth deficiency as of March 31, 2002. Additionally, MMCC signed Amendment Number 1 to the Amended and Restated Contractor Risk Agreement which states that beginning May 1, 2002, MMCC was not at risk for medical expenses incurred by its TennCare enrollees.

Because MMCC's underlying assumptions were reasonable, the TennCare Bureau and TDCI approved this plan of corrective action. At September 30, 2002, MMCC reported net worth of $6,288,568, a deficiency of $913,262 below the net worth requirement. In the interim financial statements submitted to the division as part of its plan of correction, Memphis Managed Care reported net worth of $7,511,051at November 30, 2002, an excess of $309,221 above the net worth requirement. TDCI has not verified the elimination of MMCC's net worth deficiency reported at November 30, 2002.

As previously mentioned, TDCI will continue to monitor closely MMCC's financial status and its progress in completing the claims system upgrade.

Xantus Healthplan of Tennessee
Xantus continues to be on a "no-risk" reimbursement for reasonable cost in accordance with the contract amendment between Xantus and the TennCare program.

Premier Behavioral Systems of Tennessee
At September 30, 2002, Premier reported net worth of $1.8 million, a deficiency of approximately $5 million below its net worth requirement. Therefore, on December 30, 2002, Premier entered into an Agreed Notice of Administrative Supervision with the

Department of Commerce and Insurance. Per the terms of this agreement, Premier must cure its net worth deficiency on or before June 30, 2003.

By amendment to the contractor risk agreement, the state assumed 100% of Premier's risk for the cost of delivering behavioral health services effective January 1, 2003.

Tennessee Behavioral Health, Inc.
As discussed above, the Commissioner placed TBH under Administrative Supervision on January 9, 2003.

Success of Fraud Detection and Prevention

1. Program Integrity continues to work cases referred by MCO/BHO's, general public via Web site (www.state.tn.us/tenncare/fraudabuse.html), faxes, letters, and phone calls via the hotline. Results of case reviewer/investigators are listed below;

   A. Summary of Enrollee Cases :
      a. Cases closed 5,420
      b. Recommended Terminations 1,723

      Other Adjustments to Active Cases not Terminated
         1. Income Adjusted 117
         2. Health Ins. Added 139

   B. Summary Relating to Provider Cases:
      a. Cases closed 44
      b. Active Cases 65
      c. Cases referred to TBI (1) 19
      d. Cases referred to HRB's
      e. l 10

      (1) TBI/MFCU takes the lead in cases once they are referred and Program Integrity continues to assist as requested.

2. Overpayments recovered for Nursing Home Recipients - called PA68's. These overpayments are directly related to under reporting of recipient income and/or assets.

   For the Quarter Ending 12/31/02 $382,617.35

   Note: These collections resulted from joint efforts of Program Integrity, TennCare Fiscal Services and DHS.

3. Continue to work with U.S. Attorney's Office, HHS-OIG, FBI, TBI, Commerce and Insurance, Health Related Boards, DEA and CIGNA in order to share information and help identify and prosecute Providers who violate the law.

4. Continuing to reach out to the District Attorneys across the state to solicit their help and support in prosecuting recipients who commit fraud against the

TennCare Program. This outreach has been effective, as evidenced by an increase in referrals to PIU by various Drug Task Forces.

a. Three recipients were prosecuted this quarter for committing fraud against the TennCare Program. Each recipient was convicted of a minimum of 16 counts of fraud based on TCA 71-5-118.

5. This unit provided training/networking with the following organizations during this quarter;
   a. Advanced Med & Riverbend Government Benefits Administrator, which are Medicare Public Safeguard Contractors.
   b. Senior Medicare Patrol unit.
   c. Internal Audit Team for TennCare
   d. District Attorney and staff located in the 9th Judicial District
   e. District Attorney and staff located in the 4th Judicial District
   f. Nursing Home Ombudsmen

6. Estate Recovery Legislation was passed and went into effect on 8-29-02 relating to Medicaid recipients who are 55 years of age or older and the program has paid for long term care. This program has been moved from the Long Term Care Unit to Program Integrity. Attorneys, executors, and/or responsible parties must now obtain a release from the state prior to the estate being probated. Program Integrity Unit is receiving between 40 and 50 release requests per work day.

a.	Total cases processed	2225
b.	Cases where state has claims against estate	320
c.	Collections	$717,335.83

7. Staff has been working hard with the contractor, EDS, to develop the best software system in the nation. The new TennCare Management Information System (TCMIS) will allow Program Integrity to initiate proactive measures for identifying fraud and abuse within the TennCare system. Program Integrity will be able to identify outliers for both providers and recipients. The ability to create ad hoc reports will greatly improve the speed and efficiencies of the investigations. Targeted queries will be generated on a routine basis; these queries have been developed to identify potential fraudulent claims submission. The goal behind these reports and queries is to promote improved work efficiencies, terminate individuals who are no longer eligible for TennCare benefits and prosecute individuals who have violated the federal and/or state laws.